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Non-Certification Recommendation

CLAIM #:	040519008736	**INSURED:**	Biotelemetry, Inc. / Chubb & Son (WC) - Los Angeles, CA
DOI:	02/15/2019	**CARRIER/TPA:**	Chubb & Son (WC) - Los Angeles, CA /
CLAIMANT:	**Jonathan Shockley**	**ADJUSTER:**	Mario Castro
CORVEL #:	139249073-UMO-34		

Determination Date: 11/20/2020

RFA Received Date: 11/13/2020

Provider: Babak Jamasbi, MD

Pre-cert #: 139249073-UMO-34

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, Avrom Gart, MD, CA-G59372, who is board certified in Pain Medicine (Board Certified), PM&R (Board Certified), was unable to recommend the requested treatment. The non-certification decision was made on 11/20/2020.

THERAPY

Determination	Type of Therapy	Total # Visits	Total Visits/ Week	Total Weeks	Body Part	CPT	Effective Date	Termination Date	Facility	
Requested	Acupuncture	6	0	0	Cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb	97813, 97814, 97026, 97124				
Non-Certified	Acupuncture	6	0	0	Cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb	97813, 97814, 97026, 97124	11/20/20	11/20/21		

Guidelines used in the determination process: MTUS-ACOEM-ODG. The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached. Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured workers representative, or the injured workers attorney on behalf of the

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injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30-calendar days of receipt of this decision.
You have the right to disagree with the decision affecting your claim. If you have any question about the information in this notice, please call your adjuster, Mario Castro, at (213) 612-0880. However if you are represented by an attorney, please contact your attorney instead of your adjuster.
For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

The appeals process is on a voluntary basis. Should the requesting medical provider wish to appeal the non-certification or modification decision, and/or have additional pertinent medical information which has not previously been submitted for review. You may submit a request for appeal to CorVel Corporation or the claims administrator, You may include any additional clinical information if you have any. This will be reviewed by a different reviewing physician. Requests for appeal need to be sent to CorVel Corporation or the claims administrator within ten (10) days after the receipt of the utilization review decision. A response to your appeal will be rendered within thirty (30) days after receipt of the request. Requests for appeal do not replace the objection process noted above and are voluntary.

In accordance with regulation section 9792.1(e)(5)(K), if the requesting physician wishes to speak to the reviewing physician regarding this determination, you can call (714)385-8500 to arrange an agreed upon scheduled time between the hours of 8:30a.m. to 5:30p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

Sincerely,

Anastasia Skenandore RN, CCM
Utilization Management Department
cc: Office Copy
Mario Castro
Jonathan Shockley
Farber & Co
Colantoni, Coll Marren, Phillips and
Hulbert, Barbara

****NOTE****
Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.

Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.

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State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to: DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009 FAX # (916) 605-4270**
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☒ Regular ☐ Expedited	Modification after appeal ☐
Employee Name (First, MI, Last): Jonathan Shockley	
Address: 1000 Sutter St. San Francisco, CA 94109	
Phone Number: (415) 312-4029	Employer: Biotelemetry, Inc.
Claim Number: 040519008736	Date of Injury (MM/DD/YYYY): 02/15/2019
WCIS Jurisdictional Claim Number : 201902211529547508737 4	EAMS Case Number (if applicable): NA
Employee Attorney (if known): Farber & Co	
Address: 333 Hegenberger Road #504 Oakland, CA 94621	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last): Babak Jamasbi, MD	
Practice Name:	Specialty:
Address: 1335 Stanford Ave. Emeryville, CA 94608	
Phone Number: (510) 647-5101	Fax Number: (510) 647-5105
Claims Administrator Name: Chubb & Son (WC) - Los Angeles, CA /	
Adjuster/Contact Name: Mario Castro	
Address: PO Box 30850 Los Angeles, CA 90030 90030	
Phone Number: (213) 612-0880	Fax Number:
Disputed Medical Treatment (Complete below section)	
Primary Diagnosis (Use ICD Code where Practical):	
Date of Utilization Review Determination Letter: 11/20/2020	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☒ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. Therapy : Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for	

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical reports and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:	Date:

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INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers compensation claims administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application or you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health and your claims administrator did not perform an expedited or rushed review on your physician's request, this application **must** be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

Your Right to Provide Information

You have the right to submit either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physicians requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free I -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

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Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I cart end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:	
I am a/an:	
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)	
Address:	

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City:	State:	Zip Code:
Phone Number:	Fax Number:	
State Bar Number (if applicable):		
Representative Signature:		Date:

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P&S Network

Physician Peer Review

Account No: 577058.1
Requesting Physician: Babak Jamasbi, MD

Patient Name: Jonathan Shockley
DOS: 11/20/2020
DOI: 02/15/2019
Claim No: 040519008736

Reviewing Physician:

Avrom Gart, MD
Pain Medicine (Board Certified)
PM&R (Board Certified)
CA-G59372, CO-0045996, CT-64820, LA-206746, MS-23829, NY-158934, OK-35596, TN-45545, TX-N0778

REQUESTED PROCEDURE/SERVICE	DETERMINATION
1. Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb	NON-CERTIFY

TELEPHONE COMMUNICATIONS

11/19/20 15:00 - Admin called (510) 647-5101 and I was unable to get a clear connection with Angela, the Medical Receptionist.
11/19/20 15:00 - Admin called (510) 647-5101 and I was disconnected mid-call.
11/19/20 15:15 - Admin called (510) 647-5101 and I was disconnected mid-call.
11/20/20 13:45 - Admin called (510) 647-5101 and the answering machine said the office is not accepting any calls at this time; it did not provide an option to leave a message.
11/20/20 13:45 - Admin called (510) 647-5101 and the answering machine said the office is not accepting any calls at this time; it did not provide an option to leave a message.

MEDICAL RECORDS AND DATA REVIEWED

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For the current review, I reviewed the following medical records in their entirety:

11/13/20 Dr. Jamasbi RFA
11/09/20 Dr. Jamasbi Prescription
11/06/20 Dr. Jamasbi Report
09/24/20 IMR Determination Letter
07/22/20 Dr. Gordon Report
07/21/20 Peer Review
Utilization Review Determination Report

REQUESTED SERVICES: Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb [NON-CERTIFY]

CLINICAL HISTORY

According to the medical records, the patient is a 42-year-old male who sustained an industrial injury on February 15, 2019. He has been diagnosed with cervical disc disorder with radiculopathy, bilateral upper arm soft tissue disorders related to use, overuse and pressure, and lesion of ulnar never of unspecified upper limb. His comorbidities include bronchitis, eczema, epilepsy, anxiety and sympathectomy in 2000. His previous treatments include medications, physical therapy, acupuncture, massage therapy, hand therapy, and aquatic therapy. He is a non-smoker and does not consume alcohol. The patient is not currently working. It is of note that a total of 42 sessions of acupuncture has been authorized since November 2019.

The utilization review determination report indicated that the request for 12 sessions of acupuncture for bilateral hands, lower arms, and wrists was certified on March 10, 2020. Also, the request for 12 sessions of acupuncture for bilateral lower arms was certified on June 10, 2020.

A peer review on July 21, 2020, non-certified the request for 12 sessions of acupuncture for bilateral hands, wrists and forearms, since there was no documentation of significant functional improvement with prior acupuncture.

On July 22, 2020, Dr. Gordon indicated that the patient had been sent for acupuncture treatment by Dr. Jamasbi, which provided him with temporary relief.

An IMR Final Determination Letter dated September 24, 2020, upheld the July 21, 2020, UR decision to non-certify the request of 12 sessions of acupuncture for bilateral hands, wrists and forearms, as although it was reported prior acupuncture care was beneficial in reducing symptoms, there was no documentation of medication intake reduction, or activities of daily living and range of motion improvement. After an unknown number of prior acupuncture sessions, the provider failed to document the areas previously treated, the total number of sessions completed and any measurable, progressive, significant, objective functional improvement (quantifiable response to treatment) obtained with previous acupuncture. In addition, the request was for additional 12 sessions of acupuncture, a number that exceeded the guidelines significantly for continuation of care, without extraordinary circumstances documented to consider this case as an outlier to the guidelines. Additionally, there was no clear documentation indicating whether the patient was currently undergoing an independent exercise program (conditioning-aerobic-stretching exercise program based on patient's tolerance), which was required by the guidelines. Therefore, based on the lack of documentation demonstrating medication intake reduction, work restrictions reduction, activities

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of daily living improvement directly attributable to prior acupuncture or reporting any extraordinary circumstances to override the guidelines recommendations, additional 12 sessions of acupuncture was not medically necessary.

Dr. Jamasbi performed a telemedicine evaluation (due to COVID-19 pandemic) of the patient on November 6, 2020, for pain in his arms and bilateral hands, worse on the right. The patient also complained of pain in the right deltoid region, shoulder and neck. It radiated to hands and wrists up to his elbows. The pain was associated with numbness and tingling in his right fourth and fifth digits. It was aggravated by activity and it was alleviated by conservative treatment. The patient had been attending acupuncture therapy with benefit. Massage therapy had exacerbated his pain and he had failed gabapentin that caused extreme fatigue. It was noted that the patient had been approved for 6 sessions of aqua therapy, but these were on hold since no pool was open due to the pandemic. The patient's current medications included lidocaine cream, Voltaren gel, Advil and aspirin. It was also noted that the patient had a QME with Dr. Stoller on January 23, 2020, who indicated that he was not yet maximally medically improved and had recommended upper extremity EMG and cervical spine MRI to rule out radiculopathy. An EMG on February 10, 2020, showed demyelinating ulnar mononeuropathy bilaterally across the elbow, without any evidence of median, radial or cervical radiculopathy on either side. An MRI of the cervical spine dated April 3, 2020, demonstrated a 4 mm left disc osteophyte at C5-C6 causing severe bilateral neuroforaminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. There was severe bilateral neuroforaminal stenosis at C5-C6 that might be contributing to the right shoulder and deltoid pain.

The physician requested authorization for 6 sessions of acupuncture. The physician also recommended one refill each of Voltaren 1% gel #100 and lidocaine 5% ointment #60. The patient was to follow up in 4 weeks. The patient was placed on modified duty with work restrictions.

RECOMMENDATIONS

In this case, the patient has been authorized for 42 sessions of acupuncture which significantly exceeds guideline recommendations of a maximum of 12 sessions. Despite a substantial amount of acupuncture, the records do not establish associated significant sustained pain relief or any quantifiable functional improvements. The patient remains off work. IMR recently determined that additional acupuncture is not medically necessary and appropriate. Therefore, my recommendation is to NON-CERTIFY the request for Acupuncture x6 for cervical spine, bilateral upper arms, right forearm, ulnar nerve lesion for unspecified limb.

GUIDELINES / REFERENCES

CA MTUS Treatment Guidelines (December 1, 2017)

Chronic Pain Guideline (ACOEM May 15, 2017)

Allied Health Interventions

Acupuncture for Chronic Persistent Pain
Recommended.

Acupuncture is recommended to treat chronic persistent pain. (See other guidelines for specific disorders, especially for low back pain.)

Strength of Evidence – Recommended, Insufficient Evidence (I)

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Level of Confidence – Low

Indications: Chronic persistent pain, especially torso pain. Patients should have had NSAIDs and/or acetaminophen, stretching and aerobic exercise instituted and have insufficient results. Acupuncture may be considered as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to be achieved. Consideration is for time-limited use in patients with chronic persistent pain without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is only recommended to assist in increasing functional activity levels more rapidly and the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.
Benefits: Potential to improve pain control and advance functional exercises and conditioning.
Harms: Negligible in experienced hands. Pneumothoraces have occurred and puncture of other internal organs has occurred.

Frequency/Dose/Duration: Evidence does not support specific Chinese meridian approaches, as needling the affected area appears sufficient. Patterns used in quality studies ranging from weekly for a month to 20 appointments over 6 months. However, the norm is generally no more than 8 to 12 sessions. An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures and would justify an additional 6 sessions, for a total of 12 sessions.

Indications for Discontinuation: Lack of improvement, lack of compliance with exercises, lack of incremental functional gain at the end of a treatment course, intolerance.
Rationale: There are multiple quality trials of acupuncture for treatment of many disorders, especially of low back pain (see Low Back Disorders Guideline). There are no quality trials evaluating acupuncture for treatment of non-specific chronic persistent pain.
Evidence: There are no quality studies evaluating acupuncture for the treatment of chronic persistent pain.

Acupuncture/Electroacupuncture

Not Recommended.
Acupuncture or electroacupuncture are not recommended to treat neuropathic pain.
Strength of Evidence – Not Recommended, Evidence (C)
Level of Confidence – Low

PHYSICIAN ATTESTATION

- This report has been dictated using Dragon Medical voice recognition software and is therefore subject to transcription variance.
- I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and have current relevant experience and/or knowledge to render a determination on this case under review. My license or certification is current and unrestricted. I have at least five years of accumulative full-time equivalent experience providing direct clinical care to patients over the length of my career.

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- The opinions expressed in this report are those of this evaluator and were rendered on the basis of documentation provided (outlined above) and are assumed as true and correct to the best of my knowledge except that as indicated was received from others.
- I certify that I have no material, professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator; plan fiduciary, or plan employee; the healthcare provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is subject of the review; the facility at which the recommended health care service or treatment would be provided; the developer or manufacture of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is under review, or the alternative therapy, if any, recommended by the employer; the employee or the employee's immediate family, or the employee's attorney. I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review.
- In the case of an appeal or re-review, I certify that I have identified the name of the physician who conducted the initial review, and that I have no subordinate relationship with that individual.

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ELECTRONIC PROOF OF SERVICE

I am a citizen of the United States and a resident of the County of Washington; I am employed by CorVel Corporation, am over the age of eighteen years and not a party to the within entitled action; my business address is 111 SW 5th Avenue, Suite 200, Portland, Oregon, 97204.

I am readily familiar with CorVel's practice for electronic service of correspondence that is maintained on CorVel's electronic database.

On November 20, 2020, the within letter(s) were served on the parties in said action, by sending a true copy thereof **electronically** (facsimile) on the following parties:

Anastasia.skenandore@chubb.com
Email: Anastasia.skenandore@chubb.com

Babak J Jamasbi, MD
Fax: (510) 647-5105

PT@onecallcm.com
Email: PT@onecallcm.com

Executed on November 20, 2020, at Portland, Multnomah County, Oregon, 97204.

I, Linda Grant, declare under penalty of perjury, under the laws of the **STATE OF OREGON,** that the foregoing is true and correct.

Linda A. Grant

Signature

File: 139249073 Shockley

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PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the County of Clark; I am employed by CorVel Corporation, am over the age of eighteen years and not a party to the within entitled action. My business address is 4120 SE International Way, Suite A108, Milwaukie, OR 97222. I am readily familiar with CorVel's practice for collection and processing of correspondence maintained on CorVel's electronic database for mailing with the U. S. Postal Service. Under such practice, correspondence that is printed for mail service would be put in a sealed envelope with postage theron fully prepaid and placed for collection and mailing on the same date by depositing such with the U.S. postal service in the ordinary course of business.

On November 20, 2020, the within letter(s) were served on the parties in said action, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid addressed as follows:

Babak J Jamasbi, MD
1335 Stanford Ave.
Emeryville
CA
94608

Farber & Co
333 Hegenberger Road #504

Oakland
CA
94621

Colantoni, Collins, Marren, Phillips and Tulk:
Colantoni, Coll Marren, Phillips and
201 Spear Street #1100
San Francisco
CA
94105

Jonathan Shockley
1000 Sutter St.
San Francisco
CA
94109

Executed on November 20, 2020 at Milwaukie, OR 97222.

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CORVEL

I, Becca Guimont, declare under penalty of perjury, under the laws of the **STATE OF OREGON,** that the foregoing is true and correct.

Becca Guimont

Signature

File: 040519008736, Shockley Jonathan

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End of document.